



1 2 3 4 A B C D

1-800-824-6349

[illegible]

How many prescriptions? + =

MTP STD

Please fold form here to ensure Caremark address shows through

Complete below if the information to the left is incorrect or incomplete

Primary Participant ID (required if not shown to the left)

Plan Sponsor or company name

Last Name	First Name	MI	Suffix (Sr, Jr)
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Street Address	Number
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[illegible]

City _____ State _____ Zip Code _____

This is a ☐ one time address or ☐ permanent address Daytime phone #: - -

Email address: _____ Evening phone #: - -

Please make check or money order payable to Caremark Inc. (Include ID# on all checks and money orders)

☐ Check ☐ Money Order or Cashier's Check ☐ Voucher/Coupon **Total payment enclosed:** (excluding credit card payments) \$.

☐ VISA ☐ Discover ☐ MasterCard ☐ American Express

Credit/Debit Card Number	Expiration Date
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Credit Card Holder Signature: _____ Date: _____

By checking the box below you are designating the last card # previously provided to be used on this current order. For future orders, this box must be checked each time you submit an order that you want to be charged **Credit Card on File** ☐

to your Credit Card on File. If your Credit Card on File has expired then the card # and new expiration date must be shown on this form. If you use a credit/debit card, the charge to the card will reflect the payment designated by your plan.

Credit Card on File ☐



Important Information: Unless otherwise directed, all prescriptions received on a single order or in a single envelope will be shipped together in one package.

Please turn over to provide your prescription information.

STEP 4 – PRESCRIPTION INFORMATION

Participant 1 Information: Gender: ☐ M ☐ F Date of Birth: - -

Last Name First Name MI Suffix (Sr, Jr)

Alternate Name (Nickname)

Participant is enrolled, process eligible Rx's through Medicare ☐ (check here)

Check boxes below ONLY if not previously reported.

Relationship to participant: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Sponsored <input type="checkbox"/> Widowed Dependent <input type="checkbox"/> Full Time <input type="checkbox"/> Other Student	Drug Allergies: <input type="checkbox"/> Cephalosporin [8] <input type="checkbox"/> None [10] <input type="checkbox"/> Erythromycin [72] <input type="checkbox"/> Aspirin [4] <input type="checkbox"/> Penicillin [31] <input type="checkbox"/> Codeine [97] <input type="checkbox"/> Sulfonamides/Sulfa [40] <input type="checkbox"/> Other _____	Health Conditions: <input type="checkbox"/> Heart Condition [429] <input type="checkbox"/> Arthritis [716.9] <input type="checkbox"/> High Blood Pressure [401] <input type="checkbox"/> Asthma [493] <input type="checkbox"/> High Cholesterol [272.4] <input type="checkbox"/> Diabetes [250] <input type="checkbox"/> Migraine [346.9] <input type="checkbox"/> GERD [530.11] <input type="checkbox"/> Osteoporosis [733] <input type="checkbox"/> Glaucoma [365] <input type="checkbox"/> Prostate Disorders [601] <input type="checkbox"/> Thyroid [246] <input type="checkbox"/> Other _____
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☐ **PLEASE INCLUDE EASY-OPEN CAPS** (All orders are shipped with safety caps)

Doctor / Prescriber's Last Name Doctor / Prescriber's First Name Doctor / Prescriber's Telephone # -

Participant 2 Information: Gender: ☐ M ☐ F Date of Birth: - -

Last Name First Name MI Suffix (Sr, Jr)

Alternate Name (Nickname)

Participant is enrolled, process eligible Rx's through Medicare ☐ (check here)

Check boxes below ONLY if not previously reported.

Relationship to participant: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Sponsored <input type="checkbox"/> Widowed Dependent <input type="checkbox"/> Full Time <input type="checkbox"/> Other Student	Drug Allergies: <input type="checkbox"/> Cephalosporin [8] <input type="checkbox"/> None [10] <input type="checkbox"/> Erythromycin [72] <input type="checkbox"/> Aspirin [4] <input type="checkbox"/> Penicillin [31] <input type="checkbox"/> Codeine [97] <input type="checkbox"/> Sulfonamides/Sulfa [40] <input type="checkbox"/> Other _____	Health Conditions: <input type="checkbox"/> Heart Condition [429] <input type="checkbox"/> Arthritis [716.9] <input type="checkbox"/> High Blood Pressure [401] <input type="checkbox"/> Asthma [493] <input type="checkbox"/> High Cholesterol [272.4] <input type="checkbox"/> Diabetes [250] <input type="checkbox"/> Migraine [346.9] <input type="checkbox"/> GERD [530.11] <input type="checkbox"/> Osteoporosis [733] <input type="checkbox"/> Glaucoma [365] <input type="checkbox"/> Prostate Disorders [601] <input type="checkbox"/> Thyroid [246] <input type="checkbox"/> Other _____
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☐ **PLEASE INCLUDE EASY-OPEN CAPS** (All orders are shipped with safety caps)

Doctor / Prescriber's Last Name Doctor / Prescriber's First Name Doctor / Prescriber's Telephone # -

STEP 5 – REFILL INFORMATION If space is needed for additional refill labels, apply to a Refill Order Continuation Form and enclose it with this order

Apply Caremark Refill Label here

or

write prescription number above

Apply Caremark Refill Label here

or

write prescription number above

Apply Caremark Refill Label here

or

write prescription number above

Apply Caremark Refill Label here

or

write prescription number above



By submitting this completed form to Caremark, you acknowledge that your and/or your dependents eligibility to participate under the prescription benefit administered by Caremark is subject to verification by the Plan and that you and/or your dependents do not have primary prescription coverage under any other group Plan.



INSTRUCTIONS: This form is to be used if you have more than four (4) refills to be included in your order. It is important that the cardholder's name and primary participant ID number be printed in the fields provided below.

PLEASE NOTE: THIS FORM IS FOR USE AS A CONTINUATION OF THE MAIL SERVICE ORDER FORM ONLY. A COMPLETED MAIL SERVICE ORDER FORM MUST BE SUBMITTED ALONG WITH THIS FORM.

Submitting this form without the Caremark Mail Service Order Form will cause delays in the processing of your refills. If there are four (4) or less refills, please use the Caremark Mail Service Order Form only.

Last Name (required)

First Name

MI Suffix (Sr, Jr)

Primary Participant ID (required)

STEP 5 - REFILL INFORMATION (continued from the Caremark Mail Service Order Form)

Apply Caremark Refill Label here

or

write prescription number above

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By using Caremark.com, you can:

- Order your prescription refills
- Check the status of your prescription order
- Check your benefit coverage
- Research drug information
- View your prescription history
- Locate a pharmacy near you
- View valuable health information
- Send an e-mail message to Caremark Customer Care

Prescription Refills – Convenient and Fast!

Caremark offers three easy ways to refill your mail service prescriptions:

1. Log on to the Caremark Web site at **www.caremark.com** to access Caremark online 24 hours a day, 7 days a week.
2. Mail in your prescription along with our new easy-to-use mail service order form by applying the refill sticker or providing the prescription number in the boxes provided on the Caremark Mail Service Order Form in Step 5 - Refill Information.
3. Call our helpful Customer Care representatives toll-free using the phone number on the back of your prescription ID card or within your benefit plan materials. Upon dialing the number, you will have the option to use the Caremark automated service to order your refills easily and quickly. Should you have an additional question or need to speak to a Customer Care representative, one will be available to assist you.

Important Information

Please note: Checks returned for insufficient funds shall be subject to a \$25 processing fee.

All incomplete mail service order forms will be returned to you with the original prescription unfilled, causing a delay in processing.

The submission of the Caremark Mail Service Order Form, for you or any of your dependents, authorizes the release of all information to applicable healthcare providers and all others involved in filling the prescriptions or processing the claims submitted (not applicable to research study program participants).

Caremark cannot, at any one time, dispense more than the exact amount prescribed by your doctor or the day supply limit specified by your benefit plan, whichever is less. Caremark cannot provide refills at the time of the original filling.

In connection with your benefit plan, Caremark may contact your doctor regarding your prescription. This may result in your doctor prescribing a different brand name product or a generic equivalent in place of your original prescription.

Please note: Consult your benefit plan literature regarding possible differences in coverage or co-payment between brands and generics.

You may to refuse such generic substitution. Consult your doctor or pharmacist concerning the availability of a safe, less expensive medicine for your use.

Co-payment or co-pay means the amount a participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.



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Last Name (required)

First Name

MI Suffix (Sr, Jr)

Primary Participant ID (required)

STEP 5 - REFILL INFORMATION (continued from the Caremark Mail Service Order Form)

Apply Caremark Refill Label here

or

write prescription number above

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Check ☒ it out!

The Mail Service order form has been revised for your convenience. You no longer need to rewrite the numbers of your credit card. All you have to do is check ☒ the box!!

By checking ☒ the box for "Credit Card on File," in "Step 3 - Method of Payment," you can designate that the same credit card number that you previously used to pay for your last mail service order be charged for your new prescription order. **Please note: you must check this box on every order to show your consent.**

Also, for your convenience, Caremark has developed a "Refill Order Continuation Form," to use if you are ordering more than four (4) refills. You will find this form in the reply envelope. This form can only be used with a completed Caremark Mail Service order form. Also, check out the back of this new form for helpful information.